



OFFICE USE ONLY:
DATE OF REFERRAL: _____
DIAGNOSIS: _____
EVAL DATE: _____

PATIENT REGISTRATION

NAME: _____ SSN: _____

ADDRESS: _____ DRIVERS LICENSE #: _____

CITY: _____ In an emergency, who should we contact? _____

STATE: _____ ZIP: _____ NAME: _____

EMAIL: _____ PHONE: _____ RELATION: SPOUSE
 PARENT/ GUARDIAN
 FRIEND

HOME PHONE: _____

WORK PHONE: _____ EMPLOYER: _____

CELL PHONE: _____ EMPLOYER PHONE#: _____

BIRTH DATE: _____ SEX: MALE FEMALE
(circle one) WORK ADDRESS: _____

REFERRING PHYSICIAN: _____

Please describe your injury/condition (circle one):

WORK-RELATED AUTO ACCIDENT PERSONAL INJURY LIEN NONE OF THESE

DATE OF INJURY: _____ or No injury date EMPLOYER AT DATE OF INJURY: _____

Are you represented by an attorney for this injury? YES NO EMPLOYER ADDRESS _____

If YES, please list the name of your attorney: _____ EMPLOYER PHONE _____

Please give us all pertinent information regarding your insurance coverage for this case, If you have more than one carrier, please give us information for both carriers. Please show all numbers on your card(s). We will need copies of all applicable insurance cards, as well. Thank you for your assistance.

PRIMARY INSURANCE: _____ or DO NOT BILL INSURANCE

POLICY #: _____ GROUP #: _____

TELEPHONE #: _____

INSURED NAME (As it appears on your insurance card): _____

SECONDARY INSURANCE: _____ or NO SECONDARY INSURANCE

POLICY #: _____ GROUP #: _____

TELEPHONE #: _____

INSURED NAME (As it appears on your insurance card): _____

PLEASE READ THE OTHER SIDE AND SIGN YOUR NAME ♦ THANK YOU

Spine & Sport

AUTORIZACIÓN PARA EL TRATAMIENTO DEL PACIENTE NO INTERNADO

Me han informado del tratamiento considerado necesario y que el tratamiento y los procedimientos serán realizados por terapeutas físicos, terapeutas ocupacionales, chiropractors, amaestradores atléticos, ayudantes físicas de la terapia, y fisiólogos del ejercicio empleados por Spine & Sport. La autorización es concedida para tal tratamiento y procedimientos.

Certifico que la información dada por mí está correcta y acepto la responsabilidad completa de todas las cargas. Asigno y autorizo por este medio el pago directamente a la clínica arriba nombrada de todas las ventajas de seguro. Si mi política actual prohíbe el pago directo a la espina dorsal y al deporte, mando y ordeno por este medio a la espina dorsal y al deporte para mandarme la cuenta directamente para los pagos del seguro hechos a mí. Entiendo que soy responsable de cualquier deuda después del pago del seguro, incluyendo todos los costos incurridos en recoger cualquier deuda si la cuenta llega a ser delincente, por ejemplo costos de la corte, los honorarios del 's del abogado y/o las comisiones o las cargas de agencia de colección.

AUTORIZACIÓN MÉDICA DE LOS EXPEDIENTES

Spine & Sport se autoriza por este medio para lanzar la información pertinente a mi tratamiento a cualquier doctor, asegurador, portador de la remuneración, abogado o agencia del bienestar implicada con mi caso.

PACIENTES DE MEDICARE

Certifico que la información dada por mí en solicitar el pago bajo título XVII del acto de la Seguridad Social está correcta. Autorizo cualquier sostenedor de la información médica u otra sobre mí para lanzar a la administración de Seguridad Social o sus intermediarios o portadores cualquier información necesitada para este o las demandas relacionadas de Seguro de enfermedad. Solicito que el pago de ventajas autorizadas esté hecho en mi favor.

Autorizo al clínico que trata a iniciar una queja a la comisión del seguro por cualquier razón en mi favor. Una fotocopia de esta asignación será considerada tan eficaz y válida como una original.

Firma paciente

Testigo

Fecha

Como el padre o el responsable legal, yo he leído, entiendo, y convino con todos los artículos indicados arriba y autorizó por este medio a Spine & Sport para administrar el tratamiento físico de la medicina según lo prescrito a _____.

Nombre paciente

Nombre del padre/del guarda

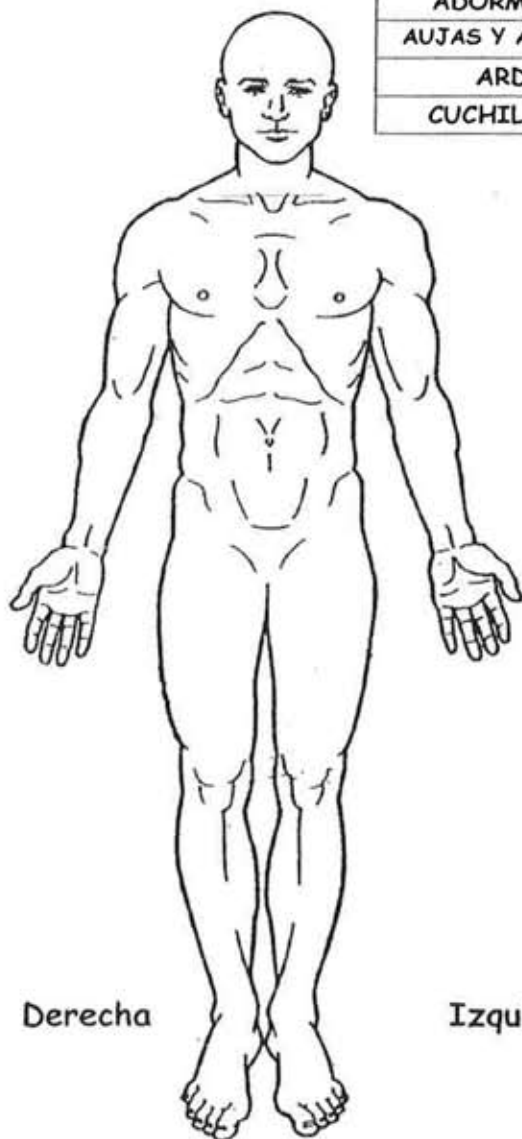
Firma del padre/ del guarda

Fecha

DONDE TIENE SU DOLOR?

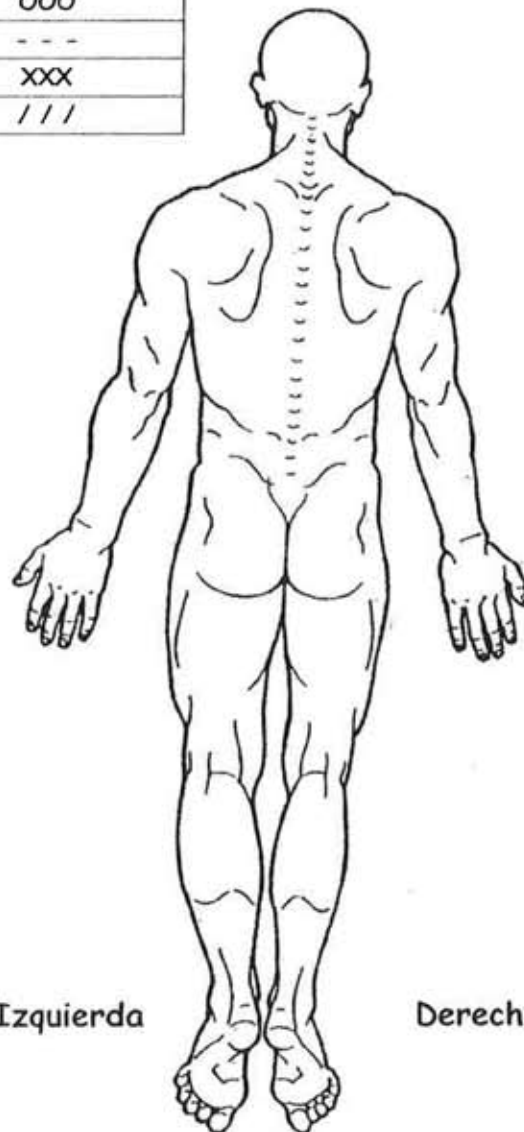
Marque las áreas de su cuerpo donde sienta las siguientes sensaciones:

CLAVES	
DOLOR	AAA
ADORMECIDO	OOO
AUJAS Y ALFILERES	- - -
ARDOR	XXX
CUCHILLASOS	///



Derecha

Izquierda



Izquierda

Derecha

POR FAVOR DE MARCAR CON UNA "X" EL GRADO DE DOLOR EN ESTE MOMENTO:

NO DOLOR

DOLOR INRESISTIBLE

DESDE SU CIRUGIA/PROCEDIMIENTO, ESTA USTED: Mejor Peor Igual

NOMBRE DEL PACIENTE: _____

FECHA: _____

Historia Medica del Paciente

Nombre: _____ ID#: _____ Fecha: _____
 Edad: _____ Estatura: _____ Peso: _____ Sexo: Masculino: Femenino:

En caso de emergencia llamar a :

Nombre: _____ Telefono: _____
 Relacion: _____

1) Problemas que deben ser tratados hoy: _____

Ha tenido tratamiento por este problema? Si No Cuando: _____

Describe el tipo de tratamiento: _____

Ha tenido cirugia por este problema? Si No

Si la respuesta es si, indique la fecha y el tipo de cirugia: _____

2) Tiene alguna otra condicion que sea causada por el ejercicio?: _____

3) Mencione los nombres de su doctor primario, internista, cardiologo, que ha visto o esta viendo:

Nombre: _____ Nombre: _____

Telefono: _____ Telefono: _____

4) Esta usted embarazada? Si No

5) Necesita asistencia con lo siguiente:

Transportacion	Si <input type="radio"/>	No <input type="radio"/>	Al Comer	Si <input type="radio"/>	No <input type="radio"/>
Mandados	Si <input type="radio"/>	No <input type="radio"/>	Cuidado Personal	Si <input type="radio"/>	No <input type="radio"/>
Labores domesticos	Si <input type="radio"/>	No <input type="radio"/>	Otro _____	Si <input type="radio"/>	No <input type="radio"/>

6) Su dolor o desabilite ha causado alguno de estos problemas:

Problemas Finandieros	Si <input type="radio"/>	No <input type="radio"/>	Problemas Familiares	Si <input type="radio"/>	No <input type="radio"/>
Problemas Emocionales	Si <input type="radio"/>	No <input type="radio"/>	Otro _____	Si <input type="radio"/>	No <input type="radio"/>

7) Ha tenido o tiene actualmente lo siguiente:

Mareos o desmayos	SI <input type="radio"/>	No <input type="radio"/>	Osteoporosis	Si <input type="radio"/>	No <input type="radio"/>
Dolor de pecho/corazon	Si <input type="radio"/>	No <input type="radio"/>	Enfermedades cardiacas	Si <input type="radio"/>	No <input type="radio"/>
Valvula/aparato (corazon)	Si <input type="radio"/>	No <input type="radio"/>	Diabetes	Si <input type="radio"/>	No <input type="radio"/>
Dolor de cabeza	SI <input type="radio"/>	No <input type="radio"/>	Inchazon en los tobillos	Si <input type="radio"/>	No <input type="radio"/>
Enfermedad de nervios	Si <input type="radio"/>	No <input type="radio"/>	Problemas del rinon	Si <input type="radio"/>	No <input type="radio"/>
Alergias	Si <input type="radio"/>	No <input type="radio"/>	Problemas de tiroides	Si <input type="radio"/>	No <input type="radio"/>
Convulciones	Si <input type="radio"/>	No <input type="radio"/>	Hernia	Si <input type="radio"/>	No <input type="radio"/>
Problemas de balance	Si <input type="radio"/>	No <input type="radio"/>	Implantes de metal	Si <input type="radio"/>	No <input type="radio"/>
Problemas de oido	Si <input type="radio"/>	No <input type="radio"/>	Problemas de la vista	Si <input type="radio"/>	No <input type="radio"/>
Colesterol elevado	Si <input type="radio"/>	No <input type="radio"/>	Presion alta	Si <input type="radio"/>	No <input type="radio"/>
Cancer	Si <input type="radio"/>	No <input type="radio"/>	Presion baja	Si <input type="radio"/>	No <input type="radio"/>
			Tuberculosis	Si <input type="radio"/>	No <input type="radio"/>
			Hepatitis	Si <input type="radio"/>	No <input type="radio"/>

8) Favor de circular una respuesta si no sabe deje sin circular:

Cigarrillos (por dia)	Nunca <input type="radio"/>	1-5 <input type="radio"/>	10-20 <input type="radio"/>	30-40 <input type="radio"/>	>50 <input type="radio"/>
Bebidas alcoholicas (por semana)	Nunca <input type="radio"/>	1-5 <input type="radio"/>	10-20 <input type="radio"/>	>20 <input type="radio"/>	
Ejercicio Cardiovascular (por semana)	Nunca <input type="radio"/>	Ocasionalmente/ Recreativo <input type="radio"/>	3+ veces por semana por lo menos 15 minutos <input type="radio"/>		

9) Condicion Respiratoria: Normal Moderada Severo (dificultad al respirar al hacer esfuerzo minimo)

For office use only: I have reviewed the Health Risk Profile and the following is appropriate:

- Contact MD with CV Screening Request Form or request results of exercise test within last 2 years;
- Further cardiovascular screening is not necessary at this time.

Clinician Signature: _____

PATIENT FINANCIAL RESPONSIBILITY POLICY NOTICE

We would like to make the billing and payment process for services as simple as possible. Please read the following information regarding the financial policies of this office.

It is customary to pay for services at the time they are rendered. For your convenience, payments may be made by cash, check credit card. If you have medical insurance coverage, a determination of your eligibility will be made, followed by a discussion of your benefits as they pertain to your treatment.

_____ 1. **PRIVATE INSURANCE:** Professional services rendered to you (or your dependents) by Spine & Sport are your sole financial responsibility. Spine & Sport will bill your insurance as a courtesy, but you are ultimately responsible for payment for your treatment. You are financially responsible for any and all balances not paid by your insurance (i.e. deductible, co-pay, coinsurance, denied charges, and fees reduced by usual & customary charges). You are required to pay your reported co-payment on the day of your visit. Any other unpaid balance due will be reflected in your monthly billing statement. Please pay close attention to statements received from your insurance company as they may report balances due prior to receiving a statement from our office. Any unpaid charges on an account for 90 days are subject to collections action.

_____ 2. **WORKER’S COMPENSATION:** If you were injured during the course of your employment, please notify the front office so that you may complete the appropriate paperwork. Coverage will be verified with your employer and we will bill the worker’s compensation carrier directly.

_____ 3. **PERSONAL INJURY/NO ATTORNEY:** If you were in an accident and you do not have an attorney, you are expected to make consistent payments as you receive treatment. You will be reimbursed for any overpayments should your case settle in your favor and payment is received by another party. You are responsible for your entire treatment cost, regardless of settlement circumstances or amounts. Please ask the front desk for available payment options.

_____ 4. **PERSONAL INJURY/ATTORNEY:** If you were in an accident and are represented by an attorney, we must have a lien on file signed by you and your attorney. This will allow you to receive treatment without payment until your case settles. You are ultimately responsible for your entire treatment cost, regardless of settlement circumstances or amounts.

_____ 5. **CASH:** If you do not have insurance, you will be expected to pay for treatment at the time of service. A discount will be extended if payment is made at the time of service or in advance.

Please direct any additional questions to the business office.

I, THE UNDERSIGNED, HAVE READ THE ABOVE INFORMATION AND UNDERSTAND MY FINANCIAL OBLIGATION TO SPINE & SPORT.

Patient (or Guardian) Signature

Date

Witness Signature

Date

Spine & Sport

HIPAA NOTICE

April 14, 2003

Dear Spine & Sport Patient:

As you may know, the federal government has enacted a new “privacy rule” designed to protect the privacy of your health information. This law applies to physicians, hospitals, other health care providers and health plans. As of April 14, 2003, under this privacy rule we are required to provide you with a copy of our Notice of Privacy Practices which summarizes how we may legally use your health information and also our duty to protect your health information.

Please acknowledge your receipt of the Spine & Sport Notice of Privacy Practices by signing the attached Acknowledgment form. We understand the importance of privacy and are committed to maintaining the confidentiality of your medical records.

Please let the Clinic Director know if you have any questions about our Spine & Sport Notice of Privacy Practices.

Spine & Sport

**ACKNOWLEDGMENT OF RECEIPT OF
SPINE & SPORT NOTICE OF PRIVACY PRACTICES**

By signing this document, I acknowledge that I have received a copy of Spine & Sport Notice of Privacy Practices.

Print Patient Name: _____

Signature of Patient or Legal Representative

Date: _____

If signed by legal representative, please describe relationship to patient:

Spine & Sport

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Clinic Name _____ Clinic Address _____

Phone #: _____ Fax: _____

Patient Name _____ Date: _____

Address _____ SS#: _____

DOB: _____

Receive Records From:

Release Records To:

Please send a copy of my records as indicated for date(s) of Treatment: _____

Operative Records Lab Reports H&P X-ray Reports
 Prenatal Records Discharge Sum Discharge Sum Other

Purpose for releasing medical information _____

**SIGNATURE OF PATIENT, PARENT
OR LEGAL GUARDIAN**

WITNESS

DATE

I understand that my express consent is required to release any health information relating to testing, diagnosis and/or treatment of alcohol or drug related medical problems, and this special consent also will apply to HIV/AIDS related diagnoses, sexually transmitted diseases and psychiatric disorders/mental health. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 C.F.R. Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. This authorization can be revoked but not retroactive to the release of information made in good faith.

SIGNATURE OF PATIENT

WITNESS

DATE

Permission to FAX records for medical emergency? Yes No

This authorization expires ninety (90) days from the date of this signature.